FOUNDATION

June 2, 2008

Dr. David Carlisle, Director
Office of Statewide Health Planning and Development
400 R Street, Sacramento, CA 95811-6213

Attn: Candace L. Diamond, Manager
Patient Data Section, Suite 270

Re: Data Elements for Inpatients (Principal Diagnosis Present on Admission Indicator/ Principal Language Spoken)

Dear Dr. Carlisle,

Health Access, a coalition of more than 200 consumer, community and other organizations, offers comments on the proposed regulation regarding data elements for inpatients, including Principal Diagnosis Present on Admission and Principal Language Spoken.

Health Access is generally supportive of the regulation as written. Our specific comments are as follows:

1. **Principal Diagnosis Present on Admission.** We believe that this change to make California hospital reporting data elements conform to national standards on the data element "Present on Admission" is warranted and is, in fact, overdue. We believe it is important to have California reporting compatible with the national standard to permit broad- based inclusion of the data for a state with such a large segment of the national population. We believe it is critical to make this change to facilitate comparisons of California data to national figures and among various states, including California.

2. **Principal Language Spoken**. We are very supportive of the inclusion of this data element to reflect the language spoken by the patient on admission to the hospital because of the influence it will have on future OSHPD outcome studies. However, we believe in §97234 (a) (4**) the "Chinese" language should be further differentiated into "Cantonese" and "Mandarin."** After consultation with the Eastern Asian Languages and Culture faculty at the University of California, Davis, we believe further differentiated is meaningful. Not all Chinese-speakers of Mandarin also speak Cantonese and vice versa. Even though Mandarin is

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the “official” language, there are regional variations, Cantonese-speakers principally come from Hong Kong and southwestern China. In addition, the language spoken is often an indicator of how long ago the family immigrated to the United States, their socio-economic status, and especially their educational level. Chinese-speakers represent such a large demographic group in California, but one that combines several language speakers together. Consequently, although the characters in written language are virtually identical, it is worth splitting those speakers into two groups representing the dialects spoken.

3. **Prompt Implementation of This Regulation.** We urge that OSHPD promptly implement this regulation due to the lengthy seven-year period of time since the passage of the statute. Despite reluctance expressed by hospitals to begin to report this data, we believe the development of this regulation has taken more than sufficient time for the industry to prepare adequately for its implementation. We believe that particularly the principal language present on admission requirement will provide vital information to evaluate health outcomes in a state as diverse as California, and contribute significant findings to the national data.

If you have questions or need further information, please contact Elizabeth Abbott, Project Director, at Health Access at (916)497-0923, extension 201.

Sincerely,

Anthony Wright
Executive Director

Acknowledgement of Comment from Health Access:

Dear Ms. Abbott,

Thank you for the Health Access comment regarding the Office of Statewide Health Planning and Development's proposed changes to the California Code of Regulations. This acknowledgment is confirmation that your comment regarding the revision of Present on Admission modifiers and the definition of Principal Language Spoken has been received. It's important to the development of good regulations and good government that interested parties take the time and make the effort to participate in the regulatory process.

Every Public Comment becomes part of the official Rulemaking File. Following review of that file by the Office of Administrative Law, all Comments and Responses will be posted on the OSHPD/MIRCal website www.oshpd.ca.gov/HID/MIRCal.

Candace L. Diamond
Manager, Patient Data Section
Office of Statewide Health Planning and Development
400 R Street, Room 271
Sacramento, CA 95811-6213

Telephone: (916) 326-3930
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****

Response to Comment submitted by Health Access:

Dear Ms Abbott,

Thank you for your supportive comments regarding the revision of the Present on Admission modifiers and the addition of Principal Language Spoken to the patient level data programs of OSHPD.

Coming into alignment with emerging national standards, where applicable, is part of our statutory mandate. We are pleased that this charge will be met and that improved data will result from the proposed Present on Admission's distinction (collected as Condition Present at Admission by OSHPD since 1996) between comorbidities and complications.

As to your recommendation to disaggregate the Chinese language category, the open text field will be the tool that is immediately available for reporting separate languages. In the longer run, the benefit of having a text field is to allow thorough assessment of all additional languages that are spoken by inpatient, emergency department or ambulatory surgery data patients. Additions, deletions, and revisions to the initially proposed list may be made in future regulatory changes as data indicate the need.

Thank you again for your thoughtful contributions to this process of improving the usefulness of OSHPD's patient level data programs.

Candace L. Diamond
Manager, Patient Data Section
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>>> Liz Alvarez <LAlvarez@primehealthcare.com> 4/18/2008 12:23 PM >>>

How would we classify a person who speaks Spanish at home but speaks English as a second language at work and social situations (truly bilingual)?

The principal language would be Spanish and English.....for example my husband, grew up speaking Spanish in the home, and now speaks Spanish to his mom but prefers English all other times?

Elizabeth Alvarez, R.H.I.A.
Director of Health Information Management
La Palma Intercommunity Hospital
7901 Walker Street
La Palma, CA 90623
(714) 670-6285
FAX (714) 562-4071
liz.alvarez@hbhoc.com

Acknowledgement of Comment:

Dear Interested Party,

Thank you for your comment. This acknowledgment is confirmation that your comment has been received. Thank you for taking the time and making the effort to participate in the regulatory process.

Every Public Comment becomes part of the official Rulemaking File. Please refer to the OSHPD/MIRCal at http://www.oshpd.ca.gov/HID/MIRCal/ to view all Comments and Responses which will be posted following review of the File by the Office of Administrative Law.

Thank you.

Irene J. Ogbonna, AGPA
Healthcare Information Division
Office of Statewide Health Planning and Development
400 R Street, Suite 270
Sacramento, CA 95811
(916) 326 3937
(FAX (916) 327 1262)
E-mail: iogbonna@oshpd.ca.gov

Response to Comment:

Dear Elizabeth Alvarez, R.H.I.A.,

Reporting the principal language spoken for a truly bilingual person should present no difficulty because the patient may state either language. A patient who can understand health professionals in more than one language is very fortunate. Your husband would be well advised to state the language in which he has the greatest medical vocabulary because his comprehension of health-related terminology is the underlying reason for asking for this information.

Candace L. Diamond, Manager
Patient Data Section
400 R Street, Suite 270
Sacramento, CA 95811

Received 05/05/08

>>> "Cindy Boyle" <CBoyle@simiasc.com> 5/5/2008 2:06 PM >>>

I would like to know what format/field length will the new language be on so we can start preparing our computer software to be ready when this goes into place.

Patients now are already mad we ask them their culture ethnicity, and adding language is not going to be something people will want to give us. I know this is open for discussion; I would like to see this not added.

Nurse Manager
SimiSurgery Center
805-306-8807 ext 103 direct to my office
805-306-8800 direct to center
805-306-8809 fax
805-444-5935 mobile
cboyle@simiasc.com

Acknowledgement of Comment:

Dear Interested Party,

Thank you for your comment. This acknowledgment is confirmation that your comment has been received. Thank you for taking the time and making the effort to participate in the regulatory process.

Every Public Comment becomes part of the official Rulemaking File. Please refer to the OSHPD/MIRCal at http://www.oshpd.ca.gov/HID/MIRCal/ to view all Comments and Responses which will be posted following review of the File by the Office of Administrative Law.

Thank you.

Irene J. Ogbonna, AGPA
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Response to Comment:

Dear Cindy Boyle,

The proposed Format and File Specifications are available on the OSHPD/MIRCal website at http://www.oshpd.ca.gov/HID/MIRCal/Proposed_Regulations.html.

OSHPD does not have the option of deleting this data element requirement from the law. In proposing these regulations OSHPD is fulfilling its obligation to enact SB 680, Figuroa, (Statutes of 2001), incorporated into the California Health and Safety Code in Section 128737(a)(5).

The principal language spoken requirement was enacted into law in an effort to determine the language needs of each patient. This was felt to be a means to ensuring that patients receive healthcare in a language that they understand. The objective is to ensure better patient outcomes.

OSHPD's regulatory language takes the legal requirements and proposes a means by which facilities can meet their legal obligation to report this new data element using MIRCal (the online Medical Information Reporting for California system) and has proposed what it considers to be the least burdensome way for this legal requirement to be reported.

OSHPD regrets that you feel that people will not want to tell you their primary language spoken. A gentle and efficient approach to collecting this data might be to use the list of languages (from the text of the regulations) on a pre-surgery form so that a patient might circle the name of their principal language or write in their principal language spoken. This "circle the data" approach may also work for collecting the Ethnicity data.

OSHPD appreciates your efforts to prepare your software to collect and report principal language spoken data.

Candace L. Diamond, Manager
Patient Data Section
400 R Street, Suite 270
Sacramento, CA 95811

>>> "Cramer, Elizabeth" <ECramer@QuadraMed.com> 5/1/2008 9:58 AM >>>

Candace & Irene,

Below are two questions and one comment about the proposed regulations.

Questions

1. In the Notice of Intent document, under the Text Overview and Policy Statement section, the first sentence of the second paragraph indicates" ....the new data element 'Principal Language Spoken' be reported with discharges and encounters occurring on and after January 1, 2008." Is this correct, or is the date really January 1, 2009?

2. In the Proposed Regulations, Section 97225, it indicates the valid Present on Admission values prior to July 1, 2008 are YES, NO or UNCERTAIN. We have communication from OSHPD in November of 2007 which
indicates effective October 1, 2007, interim values of Y, N, U, W or 1 would be accepted. Is this correct? We want to make sure this is correct since we already made software changes to report these new values as of October 1, 2007 discharges.

Comment

As a health information system vendor, we recognize we will need to make software changes as a result of these new regulations. The file format has expanded to accommodate the new data elements as well as to prepare for the collection of ICD-10 codes. Given these software changes are necessary and OSHPD has stated the intent to align state requirements with established national standards, we would like to suggest that OSHPD consider including in this regulation the move to the national standard codes for reporting the 'Source of Admission', 'Type of Admission' and 'Disposition of Patient' for Inpatient Data. The ED/AS Data already follows the national standard for reporting the 'Disposition of Patient'. Because these national standard data items already exist and software changes are necessary to produce the new file format, we do not believe these additional changes will cause a burden.

I look forward to receiving your responses to my questions and comment.

Sincerely,

Elizabeth Cramer

Principal Business Systems Analyst

QuadraMed, Inc.

12110 Sunset Hills Rd., Suite 600

Reston, VA 20190

Acknowledgement of Comment:

Dear Interested Party,

Thank you for your comment. This acknowledgment is confirmation that your comment has been received. Thank you for taking the time and making the effort to participate in the regulatory process.

Every Public Comment becomes part of the official Rulemaking File.

Following review of the Rulemaking File by the Office of Administrative Law all Comments and Responses will be posted on the OSHPD/MIRCal website www.oshpd.ca.gov/HID/MIRCal/

Thank you.

Irene J. Ogbonna, AGPA
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400 R Street, Suite 270
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Response to Comment:

Dear Elizabeth Cramer,

Thank you for your observation. The stated date should be January 1, 2009. OSHPD issued a Revised Notice (published May 9th) with the correct date.

Section 97225, indicates the valid present on admission values until June 30, 2008 are Yes, No, or Uncertain. After July 1, 2008 present on admission should be reported as Yes (Y), No (N), Unknown (U), or Clinically undetermined (W), or, Exempt from present on admission reporting (blank).

The public comment period can only be used to respond to questions and comments regarding the currently proposed regulations. It is OSHPD's long-term intent to convert the Inpatient data set to appropriate national standards at some time in the future, but that is outside the scope of the current proposal.

Candace L. Diamond, Manager
Patient Data Section
400 R Street, Suite 270
Sacramento, CA 95811

CALIFORNIA HOSPITAL ASSOCIATION
Providing Leadership in Health Policy and Advocacy

May 5, 2008

Office of Statewide Health Planning and Development
Patient Data Section
Attention: Regulations Coordinator
400 R Street, Suite 270
Sacramento, CA 95811-6213

Dear Regulations Coordinator:

The California Hospital Association (CHA), representing nearly 450 hospitals and health systems, is appreciative of OSHPD's efforts to minimize reporting burdens incurred by our members while capturing thoughtful, targeted data.

Specifically, the revision in Discharge Data Set element definitions that will bring "Present on Admission" to a standardization with current federal requirements will minimize manual abstracting intervention by hospitals in managing submission elements and will allow for more rapidly processed submissions. Any simplification of reporting elements is a "win" for hospitals and ultimately for patients in California, as more facility resources can be routed to direct patient care and less to administrative areas.

Additionally, the capture of "Principal Language Spoken" in preliminary patient assessment has long been recognized by health care professionals as critical to providing safe and efficient care. The need to communicate accurately and effectively with those seeking care is one of the most basic tenants of safe care. CHA applauds the thoughtful design of these element changes to conform with ISO standards and require minimal data capture manipulation.

The future planning for capture of ICD-10 is also to be commended as we anticipate the increased specificity that can be gained through use of ICD-10 coding.

CHA looks forward to continuing our collaborative working relationships with OSHPD. Thank you for your continued efforts to improve the health care provided in California through the use of thoughtful data collection with emphasis on minimal administrative burdens for hospitals.

Sincerely,

Pamela Lane, MS, RHIA
Vice President, Health Informatics
California Hospital Association

Debby Rogers, RN, MS
Vice President, Quality and Emergency Services
California Hospital Association

PL:lw

CALIFORNIA HOSPITAL ASSOCIATION
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Sacramento, CA
95814

325

MAY -7 AM 11:00

Candance L. Diamond, Manager
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95811$6299 C063

oshpd Office of Statewide Health Planning and Development

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Pamela Lane, MS, RHIA
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Debby Rogers, RN, MS
Vice President, Quality and Emergency Services
California Hospital Association
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May 13, 2008

Dear Ms. Lane and Ms. Rogers,

Thank you for your supportive public comment. It is appreciated. Thank you for taking the time and making the effort to participate in the regulatory process and for recognizing that OSHPD does make "efforts to improve health care provided in California through the use of thoughtful data collection with emphasis on minimal administrative burdens for hospitals."

Your Public Comment becomes part of the official Rulemaking File. Following review of the Rulemaking File by the Office of Administrative Law all Comments and Responses will be posted on the OSHPD/MIRCal website www.oshpd.ca.gov/HID/MIRCal/

Thank you again for your comment.

Candace L. Diamond

Candace L. Diamond, Manager
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E-mail: cdiamond@oshpd.ca.gov

June 2, 2008

Candace L. Diamond, Manager
Patient Data Section
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400 R Stet, Suite 270
Sacramento, CA 95811-6213
Fax: (916) 327-1262

Re: Regulations for Present on Admission and Principal Language Spoken Data Elements

Dear Ms. Diamond:

Thank you for the opportunity to comment on the new regulations related to adding language spoken as a data element to be reported with discharges and encounters. The California Pan-Ethnic Health Network, CPEJ-1N, organizes multicultural efforts to develop and advance public policies that promote equal treatment and universal access to care. Our mission is to improve access to health care and eliminate health disparities by advocating for public policies and sufficient resources to address the health needs of communities of color.

We are pleased that the Office of Statewide Health Planning and Development (OSHPD) is moving to address the health needs of our communities by requiring that language data be collected on California patients. We urge quick adoption of these regulations, with some modifications.

The provision of language services is an essential element to providing culturally appropriate, high-quality health care to the diverse communities of California, In order to ensure that interpreter services are provided to patients in a timely manner, and to ensure written materials arc provided in the appropriate language, it is essential to capture the primary language of patients, including both written and spoken language as different fields. We therefore recommend the creation of a separate field for the written language of the patient.

The list of language codes in the draft regulations will adequately address the needs of Californians by including all Medi-Cal threshold languages, and the most prevalent

languages in California, with one major exception. It is essential that the category of Chinese be disaggregated into separate, distinct fields for Cantonese and Mandarin.

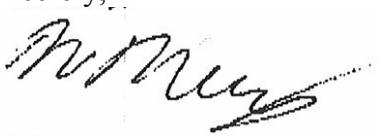
A single categorical code for the spoken language of Chinese does not take sense (it does make sense for a code capturing written language), and will not ensure appropriate language services to speakers of Cantonese or Mandarin, as the languages are distinct. Of' the approximately 47 million Medi-Cal beneficiaries, over 45 thousand speak Cantonese, and over 11 thousand speak Mandarin. Cantonese is the forth most spoken language among Medi-Cal beneficiaries, after English, Spanish, and Vietnamese. There are more Mandarin speakers in Medi-Cal than Arabic speakers. According to the California Health Interview Survey, over 62% of Chinese speakers in California do not speak English well. When you look solely at Californians who are under the poverty line, almost 85% of Chinese speakers do not speak English well, more than for any language group other than Spanish speakers.

Cantonese and Mandarin interpreters will therefore he in high demand throughout the state, and knowing that a patient speaks "Chinese" will be insufficient information to ensure a match between the patient's and interpreter's spoken language. It is essential that language coding be granular enough to capture the needs of communities, and yet also capable of being rolled up for comparisons across data sets. If separate coding fields for Mandarin and Cantonese are utilized, the data can easily be rolled up into a single Chinese category for comparison with other data sets. if the data is being collected appropriately there will be no added burden on reporting entities to collect and report the precise language spoken by a patient.

Ensuring that the collection of accurate data is accomplished appropriately is another essential factor that should be addressed in the regulations. For instance, the regulations do not specify the need to ensure the information on language spoken is collected from direct communication with the patient, and not based on a guess by looking at the patient's surname or by imagining what the language 'sounds like.'

Thank you for your consideration of our comments. We look forward to continued interaction on these requirements.

Sincerely,



Martin Martinez, MPP
Policy Director

>>> "Marty Martinez" <mmartinez@cpehn.org> 6/2/2008 4:58 PM >>>
Dear Ms. Diamond:

Thank you for the opportunity to comment on the new regulations related to adding language spoken as a data element to be reported with discharges and encounters. The California Pan-Ethnic Health Network, CPEHN, organizes multicultural efforts to develop and advance public policies that promote equal treatment and universal access to care. Our mission is to improve access to health care and eliminate health disparities by advocating for public policies and sufficient resources to address the health needs of communities of color.

We are pleased that the Office of Statewide Health Planning and Development (OSHPD) is moving to address the health needs of our communities by requiring that language data be collected on California patients. We urge quick adoption of these regulations, with some modifications.

The provision of language services is an essential element to providing culturally appropriate, high-quality health care to the diverse communities of California. In order to ensure that interpreter services are provided to patients in a timely manner, and to ensure written materials are provided in the appropriate language, it is essential to capture the primary language of patients, including both written and spoken language as different fields. We therefore recommend the creation of a separate field for the written language of the patient.

The list of language codes in the draft regulations will adequately address the needs of Californians by including all Medi-Cal threshold languages, and the most prevalent languages in California, with one major exception. It is essential that the category of Chinese be disaggregated into separate, distinct fields for Cantonese and Mandarin.

A single categorical code for the spoken language of Chinese does not make sense (it *does* make sense for a code capturing written language), and will not ensure appropriate language services to speakers of Cantonese or Mandarin, as the languages are distinct. Of the approximately 4.7 million Medi-Cal beneficiaries, over 45 thousand speak Cantonese, and over 11 thousand speak Mandarin. Cantonese is the forth most spoken language among Medi-Cal beneficiaries, after English, Spanish, and Vietnamese. There are more Mandarin speakers in Medi-Cal than Arabic speakers. According to the California Health Interview Survey, over 62% of Chinese speakers in California do not speak English well. When you look solely at Californians who are under the poverty line, almost 85% of Chinese speakers do not speak English well, more than for any language group other than Spanish speakers.

Cantonese and Mandarin interpreters will therefore be in high demand throughout the state, and knowing that a patient speaks "Chinese" will be insufficient information to ensure a match between the patient's and interpreter's spoken language. It is essential that language coding be granular enough to capture the needs of communities, and yet also capable of being rolled up for comparisons across data sets. If separate coding fields for Mandarin and Cantonese are utilized, the data can easily be rolled up into a single Chinese category for comparison with other data sets. If the data is being collected appropriately there will be no added burden on reporting entities to collect and report the precise language spoken by a patient.

Ensuring that the collection of accurate data is accomplished appropriately is another essential factor that should be addressed in the regulations. For instance, the regulations do not specify the need to ensure the information on language spoken is collected from direct communication with the patient, and not based on a guess by looking at the patient's surname or by imagining what the language 'sounds like.'

Thank you for your consideration of our comments. We look forward to continued interaction on these requirements.

Sincerely,

Martin Martinez, MPP
Policy Director
California Pan-Ethnic Health Network
654 Thirteenth St.
Oakland, CA 94612
(510)832-1160
fax: (510) 832-1175
mmartinez@cpehn.org

Acknowledgement of Comment:

Dear Mr. Martinez,

Thank you for your comment. This acknowledgment is confirmation that your comment has been received. It's important to the development of good regulations and good government that interested parties take the time and make the effort to participate in the regulatory process.

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Candace L. Diamond
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****

Response to Comment:

Dear Mr. Martinez,

Thank you for your supportive comments regarding the addition of Principal Language Spoken to the patient level data programs of OSHPD. We have the highest hopes that these new data will assist your organization as well as others with similar goals.

Regarding your recommendation to add the collection of written languages, that requirement is beyond the scope of the relevant statutory mandate and, therefore, beyond consideration in these particular regulation changes.

As to your recommendation to disaggregate the category of Chinese, the open text field will be the immediately available tool for reporting separate languages. It will provide greater granularity if needed to report languages spoken. In the longer run, the benefit of having a text field is to allow thorough assessment of volumes of any additional languages that are spoken by inpatient, emergency department or ambulatory surgery data patients. Additions, deletions, and revisions to the initially proposed list may be made in future regulatory changes as data indicate the need.

Finally, OSHPD does not regulate exactly how any information is collected. Rather, we define and clarify the required data elements. In educational and customer service efforts, we may share successful tools and best practices used by healthcare providers. In that way, we can encourage but not require that demographic information be collected from direct communication with the patient.

Thank you again for your thoughtful contributions to this process of improving the usefulness of OSHPD's patient level data programs.

Candace L. Diamond
Manager, Patient Data Section
Office of Statewide Health Planning and Development
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>>> Candace Diamond 4/29/2008 11:45 AM >>>
>>> "Munoz, Evelia" <ECampos@sach.org> 4/29/2008 11:37 AM >>>

Hi Candace,
I was review the proposed rule for principal language spoken. I could not find any specific information for newborns. What language do we select for a newborn? Do we default to the mother's language? Please advice.
Thank you,

Evelia Munoz, RHIA
Coding Manager
San AntonioCommunityHospital

Acknowledgement of Comment:

Dear Interested Party,

Thank you for your comment. This acknowledgment is confirmation that your comment has been received. Thank you for taking the time and making the effort to participate in the regulatory process.

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Thank you.

Irene J. Ogbonna, AGPA
Healthcare Information Division
Office of Statewide Health Planning and Development
400 R Street, Suite 270
Sacramento, CA 95811
(916) 326 3937
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Response to Comment:

Dear Evelia Munoz, RHIA,

The proposed new data element is called principal language spoken and the intent is to capture the language that needs to be spoken in order that each patient receives healthcare in a language that is understood. Because a newborn has no language skills, the language reported would be that of the person who is accompanying the newborn. This person is acting on behalf of the newborn and will be responsible for carrying out any healthcare directives that are given. Comprehension of health-related terminology is the underlying reason for asking for this information.

This data element should not be "defaulted" to any language; perhaps the mother's principal language spoken is Tagalog but the father's principal language spoken is English. If a newborn returns for additional care and is accompanied by a different person on a subsequent visit, then it would be appropriate to state a different language for the subsequent visits.

Candace L. Diamond, Manager
Patient Data Section
400 R Street, Suite 270
Sacramento, CA 95811

>>> MIRCal 5/2/2008 8:39 AM >>>

>>> <lmpatin@mmm.com> 5/1/2008 5:31 PM >>>
Hello!

I understand the public comment period ends on June 2nd, 2008. When can I expect a final decision on adoption of these changes?

- Principal Language Spoken
- Present On Admission changes
- Newly proposed layout for use with discharges beginning 7/1/08

As a vendor that would support these changes, we need to know as soon as possible in order to get our revised code distributed to our hospitals for OSHPD reporting.

One final question: If the proposed layout were adopted, when would the first file using these new layouts be due to MIRCal?

Thanks,

Laura Patin
Clinical Data Management Division
3M Health Information Systems, Inc.

Silver Spring office: 301-572-3800 ext 2858
Efax: 260-572-3806
lmpatin@mmm.com
www.3mhis.com

Acknowledgement of Comment:

Dear Interested Party,

Thank you for your comment. This acknowledgment is confirmation that your comment has been received. Thank you for taking the time and making the effort to participate in the regulatory process.

Every Public Comment becomes part of the official Rulemaking File. Please refer to the OSHPD/MIRCal at http://www.oshpd.ca.gov/HID/MIRCal/ to view all Comments and Responses which will be posted following review of the File by the Office of Administrative Law.

Thank you.

Irene J. Ogbonna, AGPA
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Response to Comment:

Dear Laura Patin,

At the conclusion of the public comment period the Rulemaking file will be submitted to Office of Administrative Law. OSHPD expects a final decision on adoption of these changes following a 30 working-day review of the Rulemaking File by the Office of Administrative Law. The final decision will be posted on the OSHPD/MIRCal website and emailed to all facility contacts and current Interested Parties.

If the proposed regulations are adopted as currently proposed then the first data using the new Format and File Specifications will be for Inpatient data collected on or after July 1, 2008 which has a due date of March 31, 2009. The first data using the new Format and File Specifications for Emergency Department and Ambulatory Surgery data would be collected on or after January 1, 2009 and would have a due date of May 15, 2009.

Candace L. Diamond, Manager
Patient Data Section
400 R Street, Suite 270
Sacramento, CA 95811

>>> <lmpatin@mmm.com> 6/2/2008 3:57 PM >>>

Hello Candace,

I'm sending this email per our discussion today where you encouraged me to email you our 'readiness' status for data collection regarding the inpatient proposed 7/1/08 specifications (that facilities would use for submission at the earliest in January 2009). Facilities that use ClinTrac to do their OSHPD reporting and are on our version of software that was available in December 2006 for UB-04 reporting, are equipped for this data collection now (except for Principal Language Spoken). If Principal Language Spoken is adopted, we will have a software update available this year in anticipation of this new data element required beginning January 1, 2009.

I enjoyed speaking with you today. Thanks for answering all my questions!

Laura Patin
Clinical Data Management Division
3M Health Information Systems
Phone: (800) 234-0422 x-2858 (Field office, Coeur d'Alene, ID, PST)
Fax: (707) 667-0767
Email: lmpatin@mmm.com

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Acknowledgement of Second Comment:

Dear Ms. Patin,

Thank you for your comment. This acknowledgment is confirmation that your comment has been received. It's important to the development of good regulations that interested parties take the time and make the effort to participate in the regulatory process.

Every Public Comment becomes part of the official Rulemaking File. Following review of that file by the Office of Administrative Law, all Comments and Responses will be posted on the OSHPD/MIRCal website www.oshpd.ca.gov/HID/MIRCal.

Candace L. Diamond
Manager, Patient Data Section
Office of Statewide Health Planning and Development
400 R Street, Room 271
Sacramento, CA 95811-6213

Telephone: (916) 326-3930
E-mail: cdiamond@oshpd.ca.gov

Response to Second Comment:

Dear Ms. Patin,

Thank you for your comments on the ClinTrac systems' readiness to report Present on Admission modifiers in support of your California customers as they report data to OSHPD. Your software updates to enable reporting of Principal Language Spoken will also be utilized by those facilities in compliance with statutory and regulatory requirements in California.

The active participation of the Clinical Data Management Division of 3M Health Information Systems in these efforts to improve the usefulness of healthcare information in California is appreciated.

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>>> "Steve Place" <SPlace@SphereHealth.com> 4/18/2008 10:22 AM >>>

The “Present on Admission” flag submission reference has caused problems in other states when attempting to determine the value associated with being exempt from reporting. Using a blank has caused problems when attempting to indicate whether this really means exempt or simply not recorded.

To resolve this other states chose to use the value of “1” (numeric number one) to truly indicate this “Exempt from Reporting” reference.

I suggest that you consider this modification to your submission requirements.

Steven L Place
VP Customer Service
Sphere Health Systems
22912 Mill Creek Road, Suite A
Laguna Hills, CA92653-1214
Phone: (949) 581-6734
Fax: (949) 581-6736
Email: splace@spherehealth.com

Acknowledgement of Comment:

Dear Interested Party,

Thank you for your comment. This acknowledgment is confirmation that your comment has been received. Thank you for taking the time and making the effort to participate in the regulatory process.

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Thank you.

Irene J. Ogbonna, AGPA
Healthcare Information Division
Office of Statewide Health Planning and Development
400 R Street, Suite 270
Sacramento, CA 95811
(916) 326 3937
(FAX (916) 327 1262)
E-mail: iogbonna@oshpd.ca.gov

Response to Comment:

Dear Steve Place,

Thank you for your suggestion that OSHPD consider using “1” (numeric number one) in place of the proposed blank. This option was considered. OSHPD has chosen to be consistent with the ICD-9-CM Official Guidelines for Coding and Reporting, Effective November 2006, (page 92 of 102) which use blank.

Candace L. Diamond, Manager
Patient Data Section
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Reporting Options

Y - Yes
N - No
U - Unknown
W – Clinically undetermined
Unreported/Not used – (Exempt from POA reporting)

Reporting Definitions

Y = present at the time of inpatient admission
N = not present at the time of inpatient admission
U = documentation is insufficient to determine if condition is present on admission
W = provider is unable to clinically determine whether condition was present on admission or not

Assigning the POA Indicator

Condition is on the "Exempt from Reporting" list

Leave the "present on admission" field blank if the condition is on the list of ICD-9-CM codes for which this field is not applicable. This is the only circumstance in which the field may be left blank.

POA Explicitly Documented

Assign Y for any condition the provider explicitly documents as being present on admission.

Assign N for any condition the provider explicitly documents as not present at the time of admission.

Conditions diagnosed prior to inpatient admission

Assign "Y" for conditions that were diagnosed prior to admission (example: hypertension, diabetes mellitus, asthma)

Conditions diagnosed during the admission but clearly present before admission

Assign "Y" for conditions diagnosed during the admission that were clearly present but not diagnosed until after admission occurred.

Diagnoses subsequently confirmed after admission are considered present on admission if at the time of admission they are documented as suspected, possible, rule out, differential diagnosis, or constitute an underlying cause of a symptom that is present at the time of admission.

Condition develops during outpatient encounter prior to inpatient admission

Assign Y for any condition that develops during an outpatient encounter prior to a written order for inpatient admission.

>>> <metinney@rcn.com> 4/28/2008 9:46 AM >>>
Please see attached letter
Thank you for your time,
Molly

Molly Tinney
Clinical Director
Atherton Endoscopy Center
650-363-2800

Atherton Endoscopy Center
3351 El Camino Real #220
Atherton, CA 94027

April 21, 2008

To whom it may concern,

I would like to take this opportunity to express my concern about the proposed MIRCal requirement changes. We are a small, free standing, privately owned Endoscopy Center with limited resources. We are state licensed, Medicare certified and AAAHC accredited.

The proposed reporting changes will be yet another burden on our facility by MIRCal. We had an extremely difficult time complying with the original regulations. Our scheduling/billing software will not be able to accommodate these changes so we will probably have to revert to entering data manually. This would require us to hire another fulltime person. These costs would most-likely be passed along to our patients.

We pride ourselves in the excellent care we provide to our patients. We do provide a telephone based interpretation service when ever needed. I'm not sure what purpose the principal language requirement will accomplish. We are happy to comply with all state requirements in providing health care, especially when we see that they will ensure that patients are receiving the best care possible. Unfortunately, these changes seem to be just another bureaucratic requirement with no meaning. I'm not sure how this new requirement will improve patient care.

Unfortunately, if these proposed regulations do go through we will be forced to examine the possibility of giving up our state license.

Thank you,

James Torosis, MD
Medical Director

Molly Tinney, RN
Clinical Director

Acknowledgement of Comment:

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Following review of the Rulemaking File by the Office of Administrative Law all Comments and Responses will be posted on the OSHPD/MIRCal website www.oshpd.ca.gov/HID/MIRCal/

Thank you.

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Response to Comment:

Dear James Torosis, MD and Molly Tinney, RN,

OSHPD is not at all unsympathetic to your financial and business situation. OSHPD is, however, obligated to propose regulations to enact SB 680, Figuroa, (Statutes of 2001) incorporated into the California Health and Safety Code in Section 128737(a)(5). OSHPD's regulatory language takes the legal requirements and proposes a means by which facilities can meet their legal obligation to report this new data element using MIRCal (the online Medical Information Reporting for California system).

The principal language spoken requirement was enacted into law in an effort to determine the language needs of each patient. Your provision of a telephone based interpretation service is recognition of the basic need for language-appropriate health care.

OSHPD has proposed what it considers to be the least burdensome way for this legal requirement to be reported.

Candace L. Diamond, Manager
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400 R Street, Suite 270
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